12 CV 9087

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

David Carter

(In the space above enter the full name(s) of the plaintiff(s).)

-against-

New York State Correction Officer: J. Carroll (male) who worked 7-3 tour @ complex #1 F-Block December 6th 2012 Downstate Correctional Facility

(In the space above enter the full name(s) of the defendant(s). If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed in the above caption must be identical to those contained in Part I. Addresses should not be included here.)

"UNNECESSARY use of Brute force"

COMPLAINT
under the Civil Rights Act,
42 U.S.C. § 1983

Jury Trial: ☑ Yes ☐ No
(check one)

___ Civ. _____ ( )

#1 ump

U.S. DISTRICT COURT FILED DEC 12 2012 S.D. OF N.Y.

I. Parties in this complaint:

A. List your name, identification number, and the name and address of your current place of confinement. Do the same for any additional plaintiffs named. Attach additional sheets of paper as necessary.

Plaintiff's
Name David Carter
ID# 12A5083
Current Institution Downstate Corr. Facility
Address Box F
Fishkill, New York 12524-0445

B. List all defendants' names, positions, places of employment, and the address where each defendant may be served. Make sure that the defendant(s) listed below are identical to those contained in the above caption. Attach additional sheets of paper as necessary.

Defendant No. 1
Name J. Caroll (white male) N.Y.S. Correctional services Shield # _____
Where Currently Employed Downstate Corr. Facility
Address Fishkill, New York 12524-
7-3 tour @ 1 compex "F" Block

RECEIVED DEC 12 2012 PRO SE OFFICE

Defendant No. 2 Name _____ Shield #_____
Where Currently Employed _____
Address _____

Defendant No. 3 Name _____ Shield #_____
Where Currently Employed _____
Address _____

Who did what?

Defendant No. 4 Name _____ Shield #_____
Where Currently Employed _____
Address _____

Defendant No. 5 Name _____ Shield #_____
Where Currently Employed _____
Address _____

II. Statement of Claim:

State as briefly as possible the facts of your case. Describe how each of the defendants named in the caption of this complaint is involved in this action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Attach additional sheets of paper as necessary.

A. In what institution did the events giving rise to your claim(s) occur?
Downstate Correctional Facility

B. Where in the institution did the events giving rise to your claim(s) occur?
Complex #1 "F" Block (Protective Custody)

C. What date and approximate time did the events giving rise to your claim(s) occur?
December 6th 2012 Thursday 1:35 pm during the 7-3 tour.

What happened to you?

D. Facts: ON December 6th 2012 @ 1:30 PM while in Protective Custody I was assaulted Numerous times by Correction officer: J. Carroll with a hard wooden stick (officer's night stick)

after Being attacked by a "gang member" "Bloods" in front of my cell as to where I had to defend myself against inmate who attacked me.

While ON top off inmate who attacked me with three other officers present instead of pulling me and the inmate apart from each other, Officer Carroll hit me in my back with night stick repeatedly I then was placed ON wall by other officers officer Carroll then repeatedly hit me in arm, lower right leg, back lower Spinal area where I had surgery done @ Mount Sinai Hospital by Dr. Chin. Officer carroll hit me with his stick with all of his might unnesecarily this Brute force, caused caused extreme shock and pain to my body as to where I was helpless and injured.

Was anyone else involved?

Who else saw what happened?

III. Injuries:

If you sustained injuries related to the events alleged above, describe them and state what medical treatment, if any, you required and received.

((SEE Exhibits "A" and "B".

I reciered injury to my lower right leg which they said and interfered with medical examination that it was from another incident. I recieved Black and Bruises ON lower Back and arms. I saw Medical Doctor B. DaNOBID who prescribed prescription # 240-205599 for pain two tablets three times a day or as needed IBuprofen 200mg I saw Doctor DaNOBID 12/7/2012 for prescription for Similar to TAB Motrin PAIN. D.C.

IV. Exhaustion of Administrative Remedies:

The Prison Litigation Reform Act ("PLRA"), 42 U.S.C. § 1997e(a), requires that "[n]o action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted." Administrative remedies are also known as grievance procedures.

A. Did your claim(s) arise while you were confined in a jail, prison, or other correctional facility?

Yes ✓ No ____

EXHIBIT A

IBUPROFEN 200MG TAB

GENERIC NAME: IBUPROFEN (eye-byoo-PROE-fen)

COMMON USES: This medicine is a nonsteroidal anti-inflami
headache, muscle aches, backache, and arthritis. It may also
prostaglandins. Decreasing prostaglandins helps to reduce pa

BEFORE USING THIS MEDICINE: WARNING: THE RISK O
may be increased with the use of this medicine. This risk may
problems or who are at risk for heart problems. THIS MEDICII
surgery. THE RISK OF SERIOUS AND SOMETIMES FATAL
bowel, is increased while using this medicine. These problems may occur at any time during therapy, with or without symptoms. Elderly patients are at higher risk for serious stomach problems. Ask your doctor or pharmacist for more information about this medicine and its side effects. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking heparins or tacrolimus. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking serotonin reuptake blocker medicines such as fluoxetine or citalopram, "blood thinners" such as warfarin, bisphosphonates such as alendronate or risedronate, cyclosporine, corticosteroids such as prednisone, high blood pressure medicines (including ACE inhibitors such as captopril, angiotensin II receptor antagonists such as losartan, and beta-blockers such as metoprolol), "water pills" (diuretics such as furosemide, hydrochlorothiazide, triamterene), lithium, methotrexate, or aspirin. DO NOT START OR STOP ANY MEDICINE without doctor or pharmacist approval. Inform your doctor of any other medical conditions including poorly controlled diabetes, dehydration, heart problems (such as heart failure or history of heart attack), swelling of the hands, feet, or ankles (edema), high blood pressure, history of stroke, blood clotting problems, stomach or bowel problems (such as bleeding or ulcers), history of tobacco use or alcohol use, kidney problems, liver problems, blood or bleeding problems (such as anemia), asthma, growths in the nose (nasal polyps), any allergies (especially history of angioedema with symptoms of lip, tongue, throat swelling), pregnancy, or breast-feeding. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have a history of allergy to aspirin or other NSAIDs (e.g., naproxen, celecoxib). USE OF THIS MEDICINE IS NOT RECOMMENDED if you have history of severe kidney disease or if you are going to have or have recently had coronary artery heart bypass (CABG) surgery. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

HOW TO USE THIS MEDICINE: Use this medicine exactly as directed on the package, unless instructed differently by your doctor. TAKE THIS MEDICINE with a full glass (8 oz./240 ml) of water. DO NOT lie down for 30 minutes after taking this medicine. The dosage is based on your medical condition and response to therapy. If repeat doses are needed, they are usually given 6 or 8 hours apart, or as directed by your doctor. When used in children, the dose is based on your child's weight. Read the product instructions to find the appropriate dose for your child's weight. Consult the pharmacist or doctor if you have questions or if you need help in choosing the appropriate dosage form. THIS MEDICINE MAY BE TAKEN WITH FOOD if it upsets your stomach. Taking it with food may not decrease the risk of stomach or bowel problems (such as bleeding or ulcers) that may occur while taking this medicine. Talk with your doctor or pharmacist if you experience persistent stomach upset. STORE THIS MEDICINE at room temperature, away from heat and light. Do not store in the bathroom. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do NOT take 2 doses at once.

CAUTIONS: THIS MEDICINE INCREASES YOUR RISK OF SERIOUS STOMACH OR BOWEL PROBLEMS (such as ulcers and bleeding). This risk is increased if you are elderly or are in poor health, if you have a history of smoking or drinking alcohol, if you take corticosteroid medicines (such as prednisone) or "blood thinners" (such as warfarin), or if you take this medicine for a long period of time. THIS MEDICINE MAY ALSO INCREASE YOUR RISK for certain serious heart and blood vessel problems (such as heart attack and stroke). TAKE THIS MEDICINE EXACTLY AS PRESCRIBED BY YOUR DOCTOR, at the lowest possible dose for the shortest time needed. Talk with your doctor or pharmacist for further information. DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to aspirin or any medicine containing aspirin or to a nonsteroidal anti-inflammatory drug (such as Feldene, Motrin, Naprosyn, Daypro). A severe reaction includes a severe rash, hives, breathing difficulties, or dizziness. If you have a question about whether you are allergic to this medicine or if a certain medicine is a nonsteroidal anti-inflammatory drug, contact your doctor or pharmacist. DO NOT EXCEED THE RECOMMENDED DOSE or take this medicine for longer than 10 days for pain or 3 days for fever, unless directed by your doctor. Laboratory and/or medical tests, including blood counts, liver function tests, and kidney function tests, may be performed to monitor your progress or to check for side effects, especially if you are taking this medicine for a long period of time. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are taking this medicine. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. ALCOHOL WARNING: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take this medicine or other pain relievers/fever reducers. This medicine may cause stomach bleeding. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. If you are also taking aspirin,

NYSDOCCS DOWNSTATE PHARMACY
121 RED SCHOOLHOUSE RD. FISHKILL, NY 12524 (845) 831-6600 DEA # AD91761

CARTER, DAVID **12A5083**

240-205599 B. DARNOBID 12/07/2012

DOWNSTATE PC SH-1E-001 S - Self Carry

TAKE ONE OR TWO TABLET(S) BY MOUTH THREE TIMES A DAY AS NEEDED

(0)Refills EC YOUR Rx Exp: 12/13/12

IBUPROFEN 200MG TAB **#20**

Similar to MOTRIN

CAUTION: Federal Law Prohibits Transfer of this Drug to Any Person Other than Patient for Whom Prescribed.

May cause drowsiness or dizziness

If this medication upsets your stomach, take it with crackers, bread or a small meal

Limit alcohol use while taking this drug. Daily use of alcohol may increase the risk of stomach bleeding.

EXHIBIT "B"

prescribed for Assault/use of force Dated: 12/6/2011

as prescribed by your doctor for reasons such as heart attack or stroke prevention (usually these dosages are 81-325 mg per day), continue to take the aspirin and consult your doctor or pharmacist before using this medicine. CAUTION IS ADVISED WHEN USING THIS MEDICINE IN THE ELDERLY because they may be more sensitive to the effects of this medicine, especially the risk of stomach or bowel effects (such as bleeding or ulcers), or kidney effects. FOR WOMEN: USE OF THIS MEDICINE DURING PREGNANCY has resulted in fetal and newborn death. If you think you may be pregnant, contact your doctor immediately. THIS MEDICINE IS EXCRETED IN BREAST MILK. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nausea, vomiting, diarrhea, gas, constipation, indigestion, dizziness, lightheadedness, drowsiness, or headache. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience ringing in ears. CONTACT YOUR DOCTOR IMMEDIATELY if you experience rapid or pounding heartbeat, easy bruising or bleeding, very stiff neck, or mental/mood changes. CONTACT YOUR DOCTOR IMMEDIATELY if you experience sharp or crushing chest pain; sudden shortness of breath; sudden leg pain; sudden severe headache, vomiting, dizziness, or fainting; changes in vision; numbness of an arm or leg; slurred speech; one-sided weakness; sudden unexplained weight gain; change in amount of urine produced; severe or persistent stomach pain; vomit that looks like coffee grounds; black tarry stools; itching, reddened, swollen, blistered, painful, or peeling skin; yellowing of the skin or eyes; dark urine; right-sided tenderness; severe or persistent tiredness; fever, chills, or sore throat; severe or persistent nausea; swelling of hands, ankles, feet, face, lips, eyes, throat, or tongue; difficulty swallowing or breathing; or hoarseness. AN ALLERGIC REACTION TO THIS MEDICINE is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, severe dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include severe stomach pain, coffee ground-like vomit, unusually fast or slow heartbeat, trouble breathing, extreme drowsiness, loss of consciousness, and seizures.

ADDITIONAL INFORMATION: DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children and pets. IF USING THIS MEDICINE FOR AN EXTENDED PERIOD OF TIME, obtain refills before your supply runs out.

This information may not be complete. Please consult your primary care provider for further questions or concerns.

If YES, name the jail, prison, or other correctional facility where you were confined at the time of the events giving rise to your claim(s).

Downstate Correctional Facility

B. Does the jail, prison or other correctional facility where your claim(s) arose have a grievance procedure?

Yes ____ No ____ Do Not Know ✓

C. Does the grievance procedure at the jail, prison or other correctional facility where your claim(s) arose cover some or all of your claim(s)?

Yes ____ No ____ Do Not Know ✓

If YES, which claim(s)?

D. Did you file a grievance in the jail, prison, or other correctional facility where your claim(s) arose?

Yes ✓ No ____

If NO, did you file a grievance about the events described in this complaint at any other jail, prison, or other correctional facility?

Yes ____ No ____

E. If you did file a grievance, about the events described in this complaint, where did you file the grievance? I spoke to seargent Cipollini

1. Which claim(s) in this complaint did you grieve? I Attempted to explain.

2. What was the result, if any? He said he was going to break my neck and charge me with Assault.

3. What steps, if any, did you take to appeal that decision? Describe all efforts to appeal to the highest level of the grievance process.

Fearing retaliation I chose to just file 1983 for now.

F. If you did not file a grievance:

1. If there are any reasons why you did not file a grievance, state them here:

I Fear Retaliation

2. If you did not file a grievance but informed any officials of your claim, state who you informed, when and how, and their response, if any:

Sergeant Cippolini. on December 6th 2012 approx. 1:40 PM I verbally Attempted to explain to sgt. Cippolini Sergeant stated he would break my Neck and charge me with Assault if I did not Shut up.

G. Please set forth any additional information that is relevant to the exhaustion of your administrative remedies. "Deliberate indeference"

Sergeant made statement to C.O. Caroll that he would coordinate a lie to cover up assault made against my person by C.O. Caroll. It is, and still is in my best interest to Advoid this Administration.

Note: You may attach as exhibits to this complaint any documents related to the exhaustion of your administrative remedies.

V. Relief:

State what you want the Court to do for you (including the amount of monetary compensation, if any, that you are seeking and the basis for such amount).

I seek $ 780,000 dollars (seven hundred eighty thousand dollars) for extreme shock and pain (Trauma) and paranoia symptoms TRAUMATIZED to develop in my mental physic.

VI. **Previous lawsuits:**

On these claims

A. Have you filed other lawsuits in state or federal court dealing with the same facts involved in this action?

Yes ____ No ✓

B. If your answer to A is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another sheet of paper, using the same format.)

1. Parties to the previous lawsuit:

Plaintiff _____
Defendants _____

2. Court (if federal court, name the district; if state court, name the county) _____

3. Docket or Index number _____

4. Name of Judge assigned to your case _____

5. Approximate date of filing lawsuit _____

6. Is the case still pending? Yes ____ No ____

If NO, give the approximate date of disposition _____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) _____

On other claims

C. Have you filed other lawsuits in state or federal court otherwise relating to your imprisonment?

Yes ✓ No ____

D. If your answer to C is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same format.)

1. Parties to the previous lawsuit:

Plaintiff DAVID Carter
Defendants N.Y.C. C.O. Moore

2. Court (if federal court, name the district; if state court, name the county) U.S. District S.D.N.Y. 500 Pearl Street N.Y.N.Y. 10007

3. Docket or Index number CIV-12-6531

4. Name of Judge assigned to your case VINCEN L. Briccetti

5. Approximate date of filing lawsuit August 21st, 2012

6. Is the case still pending? Yes ✓ No ____
If NO, give the approximate date of disposition ____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) ____

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 9th day of December, 2012.

Signature of Plaintiff David Carter
Inmate Number 12A5083
Institution Address Downstate
Correctional Facility
Box F
Fishkill, N.Y. 12524-0445

Note: All plaintiffs named in the caption of the complaint must date and sign the complaint and provide their inmate numbers and addresses.

I declare under penalty of perjury that on this 9th day of December, 2012, I am delivering this complaint to prison authorities to be mailed to the *Pro Se* Office of the United States District Court for the Southern District of New York.

Signature of Plaintiff: David Carter
Pro SE
N.Y.S.I.D# 4613486L

DOWNSTATE CORRECTIONAL FACILITY
BOX F
RED SCHOOLHOUSE ROAD
FISHKILL, NEW YORK 12524-0445
NAME: David Carter DIN: 12A5083

DOWNSTATE CORRECTIONAL FACILITY

90 cents

UNITED STATES POSTAGE PITNEY BOWES
02 1M $ 00.65⁰
0004279598 DEC 10 2012
MAILED FROM ZIP CODE 12524

RECEIVED DEC 12 2012 PRO SE OFFICE

USDC

Legal MAIL

1000781316

United States District Court
Southern District of New York
U.S. Courthouse - Pro SE office Room 230
500 Pearl street
New York, N.Y. 10007